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AUTHOR Booth, Dorothy E.
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ABSTRACT

Although researchers have found a correlation between health and social participation, more data are needed to determine the influence of health on the institutionalized elderly's participation. A study was conducted to explore the relationship between the perceived health status of the institutionalized elderly and their social participation. The sample was randomly drawn from a pool of elderly nursing home residents who were eligible for inclusion in the study. Interviews were conducted with 41 elderly residents. Data were obtained about the elderly's perceived health, social networks, and social participation using the Social Networks in Adult Life Questionnaire developed by Kahn and Antonucci. Results showed that 68% of the sample believed that their health hindered their social participation. Subjects reporting that health interfered with social participation reported larger personal networks. An inverse relationship was found between satisfaction with health and network size, suggesting that elderly in poor health attract more persons to their networks. These findings suggest that the institutionalized elderly continue to maintain informal social networks and that these networks, although significantly smaller than those reported by noninstitutionalized elderly, continue to provide some social support for the institutionalized elderly. (NB)

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Relationship Between Health and Social Participation Among the Institutionalized Elderly

Dorothy E. Booth, Ph.D., R.N.
College of Nursing
Wayne State University
Detroit, MI. 48202

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Relationship Between Health and Social Participation Among the Institutionalized Elderly

Dorothy E. Booth, PhD, RN
Wayne State University
College of Nursing
Detroit, MI 48202

Researchers have found a correlation between health and social participation. More data are needed to determine the influence of health on the institutionalized elderly's participation. The purpose of this study was to explore the relationship between the institutionalized elderly's perceived health status and their social participation. The sample was randomly drawn from a pool of elderly nursing home residents who were eligible for inclusion in the study. Interviews were conducted with 41 elderly residents. Data were obtained about the elderly's perceived health, social networks, and social participation using the Social Networks in Adult Life Questionnaire developed by Kahn and Antonucci. Results showed that 68% of the sample perceived their health hindered their social participation. Subjects reporting that health interfered with social participation reported larger personal networks. An inverse relationship was found between satisfaction with health and network size suggesting that elderly in poor health attract more persons to their networks. Implications of findings were discussed in regard to planning for patient care and for future research.

The elderly often have lost significant persons from their informal social networks (ISNs) prior to institutionalization. These losses may lead to decreased social support for the elderly. Social network changes and other factors that influence the level and the nature of social support received by the elderly are of concern because relationships have been found between level of the family's social participation and the elderly's well being and the care they receive in the institution. More information is needed about the institutionalized elderly's participation with network members and factors that influence their social participation.

The purposes of this research were to identify characteristics of the institutionalized elderly's ISNs and explore relationships between the elderly's perceptions about their health, and their preferences and patterns of social participation with members of their networks.

The literature suggests there is continuity in the person's pattern of social participation from earlier life to advanced old age. For example, York and Calsyn (1977) reported a positive correlation between family and elderly visitation patterns preceding institutionalization and following the elderly's placement for institutional care. Similarly, Lowenthal and Robinson (1976) proposed that long standing preference related to social participation and personal attributes are critical factors in determining whether a person will seek out or avoid social interaction with others. Pfeiffer (1977) and Lowenthal and Robinson (1976) concur that both preferences and personality influences ones social participation. Health status and availability of network opportunities may also enhance or deter the elderly's involvement with personal networks which, in turn, changes their potential for receiving

social support. Welford (1983) concluded that elderly persons who experience declines in energy or health will participate less in their social networks. This will limit their potential for receiving social support.

Three research questions were posed for this study:

1. What do the institutionalized elderly's networks look like with respect to demographic and other salient characteristics?

2. What is the relationship between the institutionalized elderly's reported health status and their preference for (a) more members in their social networks; (b) more network members to depend on for support; or (c) more contact with present network members?

3. Do the institutionalized elderly perceive that their health status keeps them from spending as much time as they would like with their network members?

METHOD:

The method of data collection for this exploratory study was the personal interview. The instrument used in interviews with elderly subjects is the Social Networks in Adult Life, Principle Questionnaire. This instrument, developed by Kahn and Antonucci (1980) was previously used in interviews with noninstitutionalized adults; items focus on network composition and supportive exchanges between subjects and their network members. Subjects report perceptions about their health, happiness and life satisfaction and indicate their preferences about their ISNs. Subjects are asked to identify (a) persons so close to them that they cannot imagine life without them, (b) other persons who are important members in their networks, and (c) others who they have not mentioned previously that they feel less close to, but who are members in their personal network.

Subjects also reported the amount and types of contacts (visits,

telephone calls, etc.) they had with network members in the last week and month. The elderly's preferences about their networks were determined by their responses to the following questions:

1. "Would you like to have an increased number of contacts, a decreased number of contacts, or about the same number of contacts with persons in your network?"

   1. Increased 2. Decreased 3. About the Same

2. "Now, about changing your network, would you want to have more people in it?"

   1. Yes 2. No

3. "Would you want it to have more people you could depend on?"

   1. Yes 2. No

Another question was used to obtain data abouth the subjects' health status:

"Compared with others your age, would you say your health is excellent, very good, good, fair or poor?"

Subjects' perceptions about whether or not their health status influenced their social participation with their network members was obtained from their responses to the following question:

"Thinking about your network, does your health keep you from spending as much time with people in your network as you would like?"

1. Yes 2. No

One other question was asked related to health:

"Overall, how satisfied are you with your own health?"

1	2	3	4	5	6	7
Completely Satisfied			Neutral			Completely Dissatisfied

Estimates have been done on these indices on the instrument and are acceptable and the internal consistency of the items has been established. A second set of questions were developed, pretested and used with staff members who were well acquainted with the subjects. This made it possible to determine the reliability of some of the data obtained from the elderly subjects. There was 90% agreement found between subjects and staff members' reports regarding subjects' age, social participation and length of institutionalization.

SAMPLE SELECTION:

Subjects were selected from two large proprietary nursing homes (325 and 257 beds), with 80% of the population in each facility provided care through Medicaid funds (skilled or intermediate care). Services provided in these two urban facilities were comparable. A purposive sample was obtained. Criteria for subject selection was explained to staff members who were appointed as liaisons for the researcher. The liaisons identified elderly residents who could respond to a series of questions. A pool of 117 residents meeting the study criteria (81 from Facility A and 36 from Facility B) were identified from the rosters of the two facilities. Names of potential subjects were randomly drawn from this pool. In all, 59 elderly were given information about the study. Of this number, 41 agreed to

participate (29 from the larger facility, and 11 from the smaller facility).

Descriptive statistics, Pearson correlation coefficients, t-tests and chi square tests were used in analysis of the data. The .05 level of probability was selected.

FINDINGS

Research Question I:

Findings are presented first for Research Question I which asked about the institutionalized elderly's networks with respect to demographic data and other salient characteristics.

The sample consisted of 41 subjects, 26 females and 15 males. Subjects ranged from 58 to 94 years of age ($\bar{X}$ = 73.7). Other demographic data for the sample are summarized in Table I.

Major health problems reported by the sample are presented in Table II. The sample had a mean of 3.8 health problems, with 1 to 9 problems reported. The interviewer sat in close proximity to each respondent, allowing those with intact vision to follow along as instructions and items were read to them and their responses documented on the questionnaire.

The mean number of children reported by subjects was 1.6 (range between 0 and 16, with 13 subjects reporting no children and 15 subjects reporting only one child. The mean number of grandchildren was 3.9; 17 subjects reported no grandchildren. Most subjects reported previous unskilled or semi-skilled occupations; there was also one R.N., one office supervisor, one artist and one professional gambler in the sample. Length of institutionalization ranged from 8 months to 12 years (M = 3.4 years) in present facilities, and a mean of 4.0 years

overall.

The overall mean number of members in subjects' ISNs was 5.8 (S.D. 3.8), with the range from Ø to 18 ISN members. Subjects reported a mean of 3.1 members who they felt so close to they could not imagine life without them whereas they reported a mean of 2.1 for "other persons who were important to them". They only reported a mean of Ø.6 network members in the third category, "do not feel as close to, but who are members in their networks". All subjects except one, reported one or more members in the first category, whereas 31 subjects (75.6%) reported ISN members in the second category. Only 15 (36%) reported ISN members in the third category.

The ISN members mentioned first (felt closest to) included daughters (8), friends (8), sisters (8), sons or stepsons (6) and brothers (3). Twenty-four subjects (58.5%) mentioned a female as the first network member in category one; a majority of the second and third ISN members were also females. Others mentioned first in the first category included husbands (2), boyfriend (1) and girlfriend (1). Seven of the 8 friends mentioned first had been known prior to the subjects' admittance to the facility. Of the 4Ø elderly who reported ISN members, 6 mentioned only 1 network member in the first category. Old friends (7), in-laws (7), nieces or nephews (7), sisters (5), brothers (3), new friends from the facility (4), daughters and sons (2), cousins (2), NCF nurses (2), aides (2), and a social worker (1), were mentioned in the second category. Networks members mentioned in the third category included: Old friends, nurses and nurses aides, brothers, great grandchildren, in-laws, new NCF friends, one doctor, one ex-wife and the volunteer librarian in the facility. Ages of

network members varied. For example, the age of the person who was identified first in category I by each subject ranged from 26 to 90 years of age. The mean age was 55.4 for those persons, whereas the mean age of members in the second category was 46.8. For the third category, the mean age was 38.0 years. Of the ISN members mentioned first, 11 (26.4%) lived within an hour's drive of the facility, 4 (10%) lived within the facility, 4 (10%) were out-of-state residents and the 21 remaining first network members (54.6%) lived more than an hour's drive from the nursing home.

The mean number of years the person in first position had been known by the elder subjects was 46.5 years. Density of the ISN (the number of persons in the ISN who know one another) also was explored. Twenty-two (55%) of the subjects with networks reported that all members knew one another, 5 subjects (12.5%) reported that few of their ISN members knew one another, another 5 (12.5%) reported that none of their ISN members were acquainted with one another and the remaining 4 (10%) had fewer than 2 network members. Of the 41 subjects, 17 (41.5%) reported their ISNs had decreased in size over the last 5 years whereas 18 (43%) reported ISNs of the same size. The remaining 6 subjects (14.6%) reported larger networks and volunteered that the birth of grand and/or great grandchildren had contributed to the larger size. Weekly ISN contacts ranged from zero to seven visits (M = 1.8). However, 16 (39%) subjects reported no visits in the past week, and 8 (20%) reported no visits from ISN members in the past month.

Pearson correlation coefficients were calculated to determine whether relationships existed between (a) the size of the network (independent variable) or (b) the number of weekly visits (independent

variable) and the three dependent variables (subjects' preferences regarding more network members, more persons to depend on for support, and more contacts with existing network members). No significant relationship was found between network size and subjects' preferences. However, a statistically significant inverse relationship was found between network size and subject preference for more contact with present network members (N = 41, r = -Ø.288, p = Ø.Ø34).

Research Question 2:

Research Question 2 focuses on the relationship between the institutionalized elderly's reported health status and their preferences for more network members, more persons to depend on for support, and more contact with present network members. From the literature, the noninstitutionalized elderly who become ill often perceive a need for additional network support but little information has been made available on the relationship between the institutionalized elderly's health status (independent variable) and their preferences related to their networks (dependent variables).

Subjects identified the health problems they had experienced in the past five years with a range of 1 to 9 problems identified (M = 3.8). See Table II. Pearson Correlation coefficients were calculated to determine whether there were relationships between the number of health problems and the subjects expressed preferences about their networks. No significant relationships were found between the number of health problems and the subjects' desire for (a) more ISN members (r = Ø.1237, df = 39, p = .22Ø), (b) more persons to depend on for support (r = Ø.Ø714, df = 39, p = .329), or (c) more contact with ISN members (r = Ø.Ø353, df = 39, p = .413).

Findings from a t-test indicate there was no significant difference in the mean number of health problems reported by the 17 subjects (42%) who preferred an increase in network size and the 24 subjects (58%) who preferred their networks to remain the same size ($t = 0.43$, $df = 39$, $p = 0.671$). Data were not obtained on subjects' perceptions about the severity of each health problem reported. This would be an important consideration for future studies. Subjects' perceptions of their overall health status were determined from their responses to the question, "Compared with others your age, would you say that your health is excellent, very good, good, fair, or poor?" Six of the 41 subjects rated their health as very good, 17 reported good health, 8 reported fair health, and 3 reported poor health. It should be noted here that a large majority of the 18 elderly who were selected in the random draw, but who declined the opportunity to participate in the study volunteered poor health or fatigue as the reason for their decision. Results of chi square tests revealed no significant relationship between subject's reported health status and their preferences for: (a) more persons in their networks ($N = 41$, $X = 1.86$, $df = 4$, $p = 0.76$), (b) more persons to depend on for support ($N = 41$, $X = 3.96$, $df = 4$, $p = 0.44$) and (c) increased contact with present ISN members, ($N = 39$, $X = 2.97$, $df = 4$, $p = 0.56$).

Research Question 3:

Research question 3 focused on whether the subjects perceived that their health kept them from spending as much time as they would like with network members. Frequencies were compiled from subjects' "yes" or "no" responses to the question "Thinking about your network, does your health keep you from spending as much time with people in your

network as you would like?". Twenty-eight of the 41 subjects (68%), or over 2/3 of the sample perceived their health interfered with their network participation whereas 13 subjects (32%) reported their health did not interefere with their social participation. Using a t-test, it was determined that the group who reported health interefered with their social participation reported a significantly greater number of network members (M = 6.6) as compared with the group who perceived their health did not interefere with social participation (M = 4.1, t = 2.10, df = 39, p = 0.042). Subjects also ranked their health on a seven point scale with choices from one (completely dissatisfied with health) to seven (completely satisfied with health). The subjects' responses ranged from 1-7 points, with a mean score of 4.0 points (the neutral position on the scale) for the sample. Pearson r coefficients were then calculated with a significant relationship found between subjects' level of satisfaction with health and the size of the network (r = 0.3238, df = 39, p = .039). This finding indicates that subjects who were less satisfied with their health were likely to have more members in their networks.

Summary:

Institutionalized elderly continue to maintain an informal social network. The networks, although significantly smaller than those reported by noninstitutionalized elderly continue to provide some social support for the institutionalized elderly. Almost 39% of the elderly reported no personal visits with network members in the past week and 20% had not seen network members in the past month. Some elderly have integrated staff members into their networks. The elderly

with smaller networks expressed a preference for more contact with present network members rather than desiring additional network members. Those elderly who reported poor or fair health had significantly larger networks, suggesting that with declining health, they are likely to attract more persons into their networks. A majority of the subjects perceived that declining health interfered with their participation with network members. The variances found in subjects' preferences regarding their networks suggest that network preferences and the elderly's perception of the ability to participate socially with others because of changing health status should be carefully assessed and considered before instituting interventions.

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Table I

Demographic Description of the Sample

	Range	Mean	Number[a]	Percentage
Educational Level	3 - 17 years	10.1		
Ethnicity and Gender				
Black Females			8	19.5
Black Males			1	2.4
Caucasian Females			18	44.0
Caucasian Males			14	34.1
Marital Status				
Married			7	17.1
Widowed			17	41.5
Divorced			4	9.7
Separated			5	12.2
Living Together			1	2.4
Never Married			7	17.1
Religious Affiliation				
Roman Catholic			23	36.6
Protestant			15	56.1
Other			1	2.4
None			2	4.9
Work Status				
Employed Only Before First Child			6	14.7
Never Employed			2	4.9
Permanently Disabled			11	26.8
Quit Job			1	2.4
Retired From Work			21	51.2

[a] $\underline{N} = 41$

Table II

Major Health Problems Reported by the Sample

Health Problems	Number	Percentage
Cataracts and/or Glaucoma	20	48.8
Arthritis or Rheumatism	19	46.3
Hypertension or High Blood Pressure	19	46.3
Diabetes	12	29.3
Stomach or Digestive Disorders	12	29.3
Circulation Problems	10	24.4
Heart Problems	10	24.4
Stroke or Cerebral Vascular Accident	9	22.0
Hearing Loss	9	22.0

Note: N = 41